BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

| | | |
|---|---|---|
| In the matter of the adoption of New Rule I, the amendment of ARM 37.86.2801, 37.86.2803, 37.86.2901, 37.86.2902, 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2910, 37.86.2912, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2943, and 37.86.2947, and the repeal of ARM 37.86.2914 pertaining to Medicaid inpatient hospital reimbursement | ) ) ) ) ) ) ) ) ) ) ) ) ) | NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT AND REPEAL |

TO: All Interested Persons

1. On July 16, 2008, at 10:00 a.m., the Department of Public Health and Human Services will hold a public hearing at the AMDD Conference Room, 555 Fuller Avenue, Helena, Montana, to consider the proposed adoption, amendment, and repeal of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process (including reasonable accommodations at the hearing site) or who need an alternative accessible format of this notice. If you need an accommodation, contact the department no later than 5:00 p.m. on July 7, 2008. Please contact Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210; (406)444-4094; fax (406)444-1970; e-mail dphhslegal@mt.gov.

3. The rule as proposed to be adopted provides as follows:

<u>RULE I COST BASED HOSPITAL, GENERAL REIMBURSEMENT</u> (1) Cost based reimbursement is applicable to exempt hospitals, preferred out-of-state hospitals with dates of admission from January 1, 2007 through September 30, 2008, and critical access hospitals (CAH).

(2) Exempt hospitals, preferred out-of-state hospitals, and CAH interim reimbursement is based on a hospital specific Medicaid inpatient cost to charge ratio (CCR), not to exceed 100%.

(3) CAH and exempt hospital final reimbursement is for reasonable costs of hospital services limited to 101% of allowable costs, as determined in accordance with ARM 37.86.2803(1).

(a) Preferred out-of-state hospital final reimbursement is for reasonable costs of hospital services limited to 100% of allowable costs, as determined in accordance with ARM 37.86.2803(1). Preferred hospitals are reimbursed on a cost basis for dates of admission from January 1, 2007 until September 30, 2008.

(4) Where applicable, the statewide CCR for cost based hospitals is determined in accordance with ARM 37.86.2905(6).

(5) Cost based hospital reimbursement for capital expenses is as determined in accordance with ARM 37.86.2912(3).

(6) Certified registered nurse anesthetist (CRNA) reimbursement for exempt and CAH hospitals is as determined in accordance with ARM 37.86.2924.

(7) All diagnostic services are included in the cost-based payment. Diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., a CT scan) are included in the first hospital's payment. This includes transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital where the services were actually performed must be between the first and second hospital and the transportation provider.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-113, MCA

4. The rules as proposed to be amended provide as follows. New matter is underlined. Matter to be deleted is interlined.

37.86.2801 ALL HOSPITAL REIMBURSEMENT, GENERAL

(1) Reimbursement for inpatient hospital services is set forth in ARM ~~37.86.2904,~~ 37.86.2905, 37.86.2907, 37.86.2910, 37.86.2912, ~~37.86.2914,~~ 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, ~~and~~ 37.86.2928, 37.86.2943, 37.86.2947, and [RULE I]. Reimbursement for outpatient hospital services is set forth in ARM 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3025, 37.86.3037, and 37.86.3109. ~~The reimbursement period will be the provider's fiscal year.~~ Cost of hospital services will be determined for inpatient and outpatient care separately. Administratively necessary days are not a benefit of the Montana Medicaid program.

(2) remains the same.

(3) Medicaid reimbursement shall not be made unless the provider has obtained authorization from the department or its designated review organization prior to providing any of the following services:

(a) and (b) remain the same.

(c) services related to organ transplantations covered under ARM 37.86.4701 and 37.86.4705; ~~or~~

(d) outpatient partial hospitalization, as required by ARM 37.88.101~~.~~;

(e) any other services for specific diagnosis or procedures that require all Medicaid providers to obtain prior authorization; or

(f) facilities designated as a Center of Excellence.

(4) Upon the request of a preferred hospital ~~located more than 100 miles outside the borders of the state of Montana~~, the department may grant retroactive authorization for the provision of the hospital's services under the following

circumstances only:

(a) through (d) remain the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15 Transmittal 17 last updated ~~February 2006 (Pub. 15)~~ May 2007, subject to the exceptions and limitations provided in the department's administrative rules. The department adopts and incorporates by reference Pub. 15, which is a manual published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of Pub. 15 may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(a) Hospitals located in the state of Montana providing inpatient and outpatient hospital services reimbursement under the retrospective cost based methodology for a hospital that is identified by the department as a distinct part rehabilitation unit are subject to the provisions regarding cost reimbursement and coverage limits and rate of increase ceilings specified in 42 CFR 413.30 through 413.40 (2002), except as otherwise provided in these rules. This provision applies to distinct part rehabilitation units only through January 31, 2003. The department adopts and incorporates by reference 42 CFR 413.30 through 413.40 (2002). A copy of 42 CFR 413.30 through 413.40 (2002) may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(b)~~ (a) For cost report periods ending on or after July 1, 2003, for each hospital which is not a sole community hospital, critical access hospital, or exempt hospital as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1).

~~(c)~~ (b) For cost report periods ending on or after July 1, 2003, for each hospital which is a sole community hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined in accordance with (1).

~~(d)~~ (c) For cost report periods ending on or after January 1, 2006, for each hospital which is a critical access or exempt hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of hospital services shall be limited to 101% of allowable costs, as determined in accordance with (1).

~~(c)~~ (d) For cost report periods ending on or after January 1, 2007 through September 30, 2008, for each hospital which is a preferred out-of-state hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of inpatient hospital services shall be limited to 100% of allowable costs, as determined in accordance with (1).

(2) All hospitals reimbursed under ARM ~~37.86.2904,~~ 37.86.2905, 37.86.2907, 37.86.2910, 37.86.2912, ~~37.86.2914,~~ 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2943, 37.86.2947, ~~or~~ 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3025, 37.86.3037, 37.86.3109, or [RULE I] must submit, as provided in (3), an annual Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.

(3) All hospitals reimbursed under ARM ~~37.86.2904,~~ 37.86.2905, 37.86.2907, 37.86.2910, 37.86.2912, ~~37.86.2914,~~ 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2943, 37.86.2947, ~~or~~ 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3025, 37.86.3037, 37.86.3109, or [RULE I] must file the cost report with the Montana Medicare intermediary and the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

(a) through (4) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA

37.86.2901 INPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) remains the same.

(2) "All patient refined diagnosis related groups (APR-DRGs)" means DRGs that classify each inpatient case based on claim information such as diagnosis, procedures performed, patient age, patient sex, and discharge status.

(2) remains the same but is renumbered (3).

(4) "Base price" means a dollar amount, including capital expenses, that is reviewed by the department each year to allow for appropriation neutrality.

(3) remains the same but is renumbered (5).

(6) "Center of Excellence" means a hospital specifically designated by the department as being able to provide a higher level of comprehensive care that is not available elsewhere.

(4) remains the same but is renumbered (7).

(8) "Cost based hospital" means a licensed acute care hospital that is reimbursed on the basis of allowable cost.

~~(5)~~ (9) "Cost outlier" means an additional payment for unusually high cost case that exceeds the cost outlier thresholds as set forth in ARM 37.86.2916.

(6) and (7) remain the same but are renumbered (10) and (11).

~~(8)~~ (12) "Discharging hospital" means a hospital, other than a transferring hospital, that formally discharges an inpatient. Release of a patient to another hospital, as described in ~~(24)~~ (31) or a leave of absence from the hospital will not be recognized as a discharge. A patient who dies in the hospital is considered a discharge.

(13) "Distinct part psychiatric unit" means a psychiatric unit of an acute care general hospital that meets the requirements of 42 CFR part 412 (2008).

~~(9)~~ (14) "Distinct part rehabilitation unit" means a rehabilitation unit of an acute care general hospital that meets the requirements in 42 CFR 412.25 and 412.29 (1992).

~~(10)~~ (24) "~~DRG~~ Prospective payment system (PPS) hospital" means a hospital reimbursed pursuant to the diagnosis related group (DRG) system. DRG hospitals are classified as such by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR part 412 (2008).

(11) through (14) remain the same but are renumbered (15) through (18).

~~(15)~~ (19) "Inpatient hospital services" means services that are ordinarily furnished in ~~a~~ an acute care hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other practitioner as permitted by federal law, and that are furnished in an institution that:

(a) is maintained primarily for the care and treatment of patients with disorders other than:

(i) tuberculosis; or

(ii) mental diseases, except as provided in ~~(15)~~ (19)(d);

(b) is licensed or formally approved as ~~a~~ an acute care hospital by the officially designated authority in the state where the institution is located;

(15)(c) and (d) remain the same but are renumbered (19)(c) and (d)

.

(20) "Long term care hospital (LTCH)" means an acute care hospital as defined in 42 CFR 412.

(16) and (17) remain the same but are renumbered (21) and (22).

~~(18)~~ (23) "Preferred out-of-state hospital" means a hospital located more than 100 miles outside the borders of Montana that has signed a contract with the department to provide specialized services prior approved by the department. The classification of preferred out-of-state hospital is eliminated effective September 30, 2008.

(19) remains the same but is renumbered (25).

(26) "Relative weight" means a weight assigned from a national database from 3M that reflects the typical resources consumed per APR-DRG.

(20) through (22) remain the same but are renumbered (27) through (29).

~~(23)~~ (30) "Supplemental disproportionate share hospital" means a hospital in Montana which meets the criteria in ARM 37.86.2925 and 37.86.2931.

(24) through (26) remain the same but are renumbered (31) through (33).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, 53-6-149, MCA

37.86.2902 INPATIENT HOSPITAL SERVICES, REQUIREMENTS

(1) through (3)(g) remain the same.

(4) Alcohol and drug ~~treatment~~ detoxification services are limited to:

(a) detoxification services up to four days, except that more than four days may be covered if concurrently authorized by the department or the designated review organization and a hospital setting is required; or

(b) the department or the designated review organization determines that the patient has a concomitant condition that must be treated in the inpatient hospital setting, and the alcohol and drug treatment is a necessary adjunct to the treatment of the concomitant condition.

(5) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2904 INPATIENT HOSPITAL SERVICES, BILLING REQUIREMENTS

(1) Inpatient hospital service providers shall be subject to the billing requirements set forth in ARM 37.85.406. At the time a claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice: "Notice to physicians: Medicaid payment to hospitals is based ~~in part~~ on all of each patient's ~~principal and secondary~~ diagnoses and the ~~major~~ procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment or civil penalty under applicable federal laws."

(2) through (4) remain the same.

(5) Except for hospital resident cases, a provider may not submit a claim until the recipient has been either:

(a) remains the same.

(b) a patient at least 30 days, in which case the hospital may bill every 31 days;

~~(b)~~ (c) transferred to another hospital; ~~or~~

~~(c)~~ (d) designated by the department as a hospital resident as set forth in ARM ~~37.86.2901.~~ 37.86.2921; or

(e) cost based hospitals may split bill at their fiscal year end.

~~(6) The Medicaid statewide average cost to charge ratio excluding capital expenses is 50%.~~

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2905 INPATIENT HOSPITAL SERVICES, GENERAL REIMBURSEMENT (1) ~~Except as provided in (2), which is applicable to exempt hospitals, preferred out-of-state hospitals, critical access hospitals (CAH), and inpatient hospital service providers, including inpatient rehabilitation services and services in a setting that is identified by the department as a distinct rehabilitation unit,~~ Prospective payment system (PPS) hospitals including in-state PPS facilities,

distinct part units, border facilities, all out of state facilities and Center of Excellence facilities will be reimbursed under the All Patient Refined Diagnosis Related Groups (APR-DRG) prospective payment system described in ARM 37.86.2907, 37.86.2912, ~~37.86.2914,~~ 37.86.2916, 37.86.2918, and 37.86.2920~~, and 37.86.2924~~.

(2) ~~Exempt hospital, preferred out-of-state hospitals, and CAH interim~~ Interim reimbursement for cost based facilities, including exempt facilities and CAH facilities, is based on a hospital specific Medicaid inpatient cost to charge ratio~~,~~ not to exceed 100%. ~~Exempt hospitals, preferred out-of-state hospitals, and CAHs~~ Cost based facilities will be reimbursed their allowable costs as determined according to ARM 37.86.2803.

~~(3) Preferred out-of-state hospitals must sign individual agreements with the department agreeing to reimbursement requirements under ARM 37.86.2947 and prior authorization requirements under ARM 37.86.2801.~~

~~(a) Preferred out-of-state hospitals must agree to all department rules applicable to inpatient hospital providers.~~

~~(4)~~ (3) Except as otherwise specified in these rules, facilities reimbursed under the APR-DRG prospective payment system may be reimbursed, in addition to the prospective APR-DRG rate, for the following:

~~(a) capital-related costs as set forth in ARM 37.86.2912;~~

~~(b) medical education costs as set forth in ARM 37.86.2914;~~

~~(c)~~ (a) cost outliers as set forth in ARM 37.86.2916;

~~(d)~~ (b) readmissions and transfers, as set forth in ARM 37.86.2918;

~~(e)~~ (c) hospital residents, as set forth in ARM 37.86.2920;

~~(f)~~ (d) disproportionate share hospital payments as provided in ARM 37.86.2925;

~~(g) certified registered nurse anesthetist costs as provided in ARM 37.86.2924;~~

~~(h)~~ (e) qualified rate adjustor payments, as set forth in ARM 37.86.2910; and

~~(i)~~ (f) hospital reimbursement adjustor payments as provided in ARM 37.86.2928.

(4) PPS facilities may interim bill for stays exceeding 30 days at the same hospital.

(a) The interim rate will be a flat per diem rate times the number of covered days for the claim.

(b) Upon discharge the interim claims will be voided or credited by the hospital and the hospital must bill a single admit through discharge claim which will be paid by APR-DRG.

(c) The hospital must obtain authorization to interim bill prior to submission of the first claim and must provide medical records upon request of the department or its designated review organization for continued stay reviews.

(5) The Medicaid statewide average PPS inpatient cost to charge ratio including capital expenses is 52%.

(6) The Medicaid statewide average cost based inpatient cost to charge ratio including capital expenses is 53%.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2907 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, APR-DRG PAYMENT RATE DETERMINATION (1) The department's APR-DRG prospective payment rate for inpatient hospital services is based on the classification of inpatient hospital discharges to APR-DRGs. The procedure for determining the APR-DRG prospective payment rate is as follows:

(a) ~~Prior to~~ Effective October 1st of each year, the department will assign ~~a~~ an APR-DRG to each Medicaid patient discharge in accordance with the current ~~Medicare~~ APR-grouper program version, as developed by 3M Health Information Systems. The assignment of each APR-DRG is based on:

(i) the ICD-9-CM principal diagnoses;

(ii) ~~the~~ all ICD-9-CM secondary diagnoses;

(iii) ~~the~~ all ICD-9-CM medical procedures performed during the recipient's hospital stay;

(iv) the recipient's age;

(v) the recipient's sex; and

(vi) the recipient's discharge status.

(b) For each APR-DRG, the department determines a relative weight using a national database from 3M that reflects the cost of hospital resources used to treat cases ~~in that DRG relative to the statewide average cost of all Medicaid hospital cases~~. The relative weights have been recentered so that the average Montana Medicaid stay has a base weight of 1.00. Adjustments are applied to specific APR-DRG weights to reflect department policy. The relative weight for each APR-DRG is available upon request from Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(c) The department computes a Montana average base price per case. ~~This average base price per case is $1980 excluding capital expenses, medical education, and disproportionate share hospital payments effective for services provided from August 1, 2003 through December 31, 2005. For services provided January 1, 2006 through June 30, 2006, the average base price per case is $2037 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided between July 1, 2006 and September 30, 2007, the average base price is $2118 excluding capital expenses, medical education, and disproportionate share hospital payments. For services provided on or after October 1, 2007, the average base price is $2187 and for services on or after July 1, 2008, the average base price is $2220 excluding capital expenses, medical education, and disproportionate share hospital payments.~~ Effective October 1, 2008 the average base price, including capital expenses, is $3,960. Disproportionate share payments are not included in this price.

(i) The average base price for Center of Excellence hospitals, including capital expenses, is $6,545. Disproportionate share payments are not included in this price.

(ii) The average base for distinct part rehabilitation units and long term care hospitals (LTCH), including capital expenses, is $8,718. Disproportionate share payments are not included in this price.

(d) The relative weight for the assigned APR-DRG is multiplied by the average base price per case to compute the APR-DRG prospective payment rate for that Medicaid patient discharge ~~except where there is no weight assigned to a DRG. Referred to as "exempt", the unweighted DRG will be paid at the statewide cost to charge ratio as defined in ARM 37.86.2904~~.

~~(2) For those Montana hospitals designated by the department after July 15, 2005 as having met the requirements for a specialty (level II) and subspecialty (level III) neonatal intensive care facility as provided in the Guidelines for Perinatal Care, Fifth Edition (2002), published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, reimbursement for neonatal DRGs 385 through 389 will be actual allowable cost determined on a retrospective basis, with allowable costs determined according to ARM 37.86.2803. The guidelines are adopted and incorporated by reference and are available through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. In addition, such facilities:~~

~~(a) will be reimbursed on an interim basis during each facility's fiscal year. The interim rate will be a percentage of usual and customary charges, and the percentage will be the facility-specific cost to charge ratio, determined by the department in accordance with Medicare reimbursement principles.~~

~~(b) may split bill when total charges reach $100,000. The first interim split bill must total at least $100,000 in charges.~~

~~(c) will not receive any cost outlier payment with respect to such discharges or services.~~

~~(3)~~ (2) The Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), and outlier thresholds are contained in the APR-DRG Table of Weights and Thresholds (effective October 1, ~~2007~~ 2008) published by the department. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds (effective October 1, ~~2007~~ 2008). Copies may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2910 INPATIENT HOSPITAL REIMBURSEMENT, QUALIFIED RATE ADJUSTMENT PAYMENT (1) Subject to the availability of sufficient county and federal funding, restrictions imposed by federal law, and the approval of the state plan by the Centers for Medicare and Medicaid Services (CMS), the department will pay, in addition to the Medicaid payments provided for in ARM ~~37.86.2904,~~ 37.86.2905, 37.86.2907, 37.86.2910, 37.86.2912, ~~37.86.2914,~~ 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, ~~and~~ 37.86.2928, 37.86.2943, 37.86.2947, and [RULE I] a qualified rate adjustment payment to an eligible county owned, operated, or partially county funded rural hospital in Montana as provided in ARM 37.86.2810.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2912 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CAPITAL-RELATED COSTS (1) The department will reimburse inpatient hospital service providers located in the state of Montana for capital-related costs that are allowable under Medicare cost reimbursement principles as set forth at 42 CFR 412.113(a), as amended through October 1, ~~2005~~ 2007. The department adopts and incorporates by reference 42 CFR 412.113(a) and (b), as amended through October 1, ~~2005~~ 2007, which set forth Medicare cost reimbursement principles. Copies of the cited regulation may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(2) Prior to settlement based on audited costs, the department will make interim payments for each facility's capital-related costs as follows:~~

~~(a) The department will identify the facility's total allowable Medicaid inpatient capital-related costs from the facility's most recent audited or desk reviewed cost report. These costs will be used as a base amount for interim payments. The base amount may be revised if the provider can demonstrate an increase in capital-related costs as a result of an approved certificate of need that is not reflected in the base amount.~~

~~(b) All border and out-of-state hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per claim as a final capital-related cost payment. The statewide average capital cost per claim is $336.~~

~~(c) The department will make interim capital add-on payments with each in-state DRG inpatient hospital claim paid.~~

(2) Capital expenses are included within the APR-DRG base payment and will not be paid separately to PPS facilities and will not be cost settled.

~~(d)~~ (3) The interim payment made to CAH and exempt facilities is based on the hospital specific cost to charge ratio and includes capital costs.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2916 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, COST OUTLIERS (1) In addition to the APR-DRG payment, providers reimbursed under the APR-DRG prospective payment system may receive payment as provided in this rule for cost outliers for APR-DRGs.

(2) To receive payment for a cost outlier, the combined cost of the medically necessary days and services of the inpatient hospital stay, as determined by the department, must exceed the cost outlier threshold established by the department for the APR-DRG.

(3) The department determines the outlier reimbursement for cost outliers for all hospitals and distinct part units, entitled to receive cost outlier reimbursement, as follows:

(a) computing an estimated cost for the inpatient hospital stay by multiplying the allowed charges for the stay by the statewide ~~Medicaid~~ average PPS cost to charge ratio set forth in ARM ~~37.86.2904~~ 37.86.2905;

(b) and (c) remain the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2918 INPATIENT HOSPITAL, READMISSIONS, PARTIAL ELIGIBILITY, OUTPATIENT BUNDLING, AND TRANSFERS (1) This rule states the billing requirements applicable to inpatient hospital readmissions, partial eligibility, outpatient bundling, and transfers. Sections (2), ~~and~~ (3), and (4) apply to ~~DRG hospitals only~~ PPS facilities unless otherwise noted. ~~Sections (4) and (5) apply to DRG, out-of-state and border hospitals.~~ Subsection (2)(d) applies to PPS facilities.

(2) All readmissions occurring within 30 days will be subject to review to determine whether additional payment as a new APR-DRG or as an outlier is warranted. As a result of the readmission review, the following payment changes will be made:

(a) If it is determined that complications have arisen because of premature discharge and/or other treatment errors, then the APR-DRG payment for the first admission must be altered by combining the two admissions into one for payment purposes; or

(b) remains the same.

(c) A patient readmission occurring in an inpatient rehabilitation hospital ~~within 72 hours~~ or a rehabilitation distinct part unit three days prior to the date of discharge must be combined into one admission for payment purposes, with the exception of discharge to an acute care hospital for surgical APR-DRGs.

(d) All ~~diagnostic services~~ hospital inpatient and outpatient services except dialysis services are included in the APR-DRG payment. ~~Diagnostic services~~ Services that are performed at a second hospital because the services are not available at the first hospital (e.g., a CT scan) are included in the first hospital's ~~DRG~~ payment. This includes transportation to the second hospital and back to the first hospital. Arrangement for payment to the transportation provider and the second hospital where the services were actually performed must be between the first and second hospital and the transportation provider.

(3) A transfer, for the purpose of this rule, is limited to those instances in which a patient is transferred for continuation of medical treatment between two hospitals or distinct part units, one of which is paid under the Montana Medicaid prospective payment system.

(a) A transferring hospital or distinct part unit reimbursed under the APR-DRG prospective payment system is paid for the services and items provided to the transferred recipient, the lesser of:

(i) a per diem rate of two times the average per diem amount for the first inpatient day plus one per diem payment for each subsequent day of inpatient care. The per diem payment is determined by dividing the sum of the APR-DRG payment for the case as computed in ARM 37.86.2907 ~~and the appropriate outlier, capital, medical education, and DSH add-ons as computed in ARM 37.86.2912, 37.86.2914, 37.86.2916, and 37.86.2925, if any, by the statewide~~ by the national average length

of stay for the DRG. Outlier and add-on payments are then added if applicable after the transfer payment is computed; or

(ii) the sum of the APR-DRG payment for the case as computed in ARM 37.86.2907 and the appropriate outlier, ~~capital, medical education, and DSH~~ and add-ons, if applicable, as computed in ARM ~~37.86.2912, 37.86.2914,~~ 37.86.2916, and 37.86.2925~~, if any~~.

(b) A discharging hospital or distinct part unit (i.e., the hospital to which the recipient is transferred) reimbursed under ARM 37.86.2907 is paid the full APR-DRG payment plus any appropriate outliers~~, capital, medical education, and DSH~~ and add-ons, if ~~any~~ applicable.

(4) Outpatient hospital services, including provider based entity hospital outpatient services, ~~other than diagnostic services~~ emergency room services, and diagnostics services (including clinical diagnostic laboratory tests) that are provided ~~within the 24 hours preceding~~ the day of or the day before the inpatient hospital admission are deemed to be inpatient services and must be bundled into the inpatient claim.

~~(5) Diagnostic services (including clinical diagnostic laboratory tests) provided in any outpatient hospital setting including provider based entities within 72 hours prior to the date of admission are deemed to be inpatient services and must be bundled into the inpatient claim.~~

(5) A hospital or distinct part unit reimbursed under the APR-DRG prospective payment system is paid for the services and items provided to a recipient who is eligible for only part of the inpatient stay, the lesser of:

(a) a rate of one per diem payment for each eligible day of inpatient care. The per diem payment is determined by dividing the sum of the APR-DRG payment for the case as computed in ARM 37.86.2907 plus outlier if applicable, by the national average length of stay for the DRG. Add-on payments are then added if applicable; or

(b) the sum of the APR-DRG payment for the case as computed in ARM 37.86.2907 and the appropriate outlier and add-ons, if applicable, as computed in ARM 37.86.2916 and 37.86.2925.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2920 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, HOSPITAL RESIDENTS (1) Payment for hospital residents will be made as follows:

(a) ~~upon~~ prior to obtaining hospital residency status, claims for that recipient may be billed on an interim basis as provided in ARM 37.86.2905(4);

(b) final payment for the first 180 days of inpatient care will be the APR-DRG payment for the case as computed in ARM 37.86.2907 ~~and~~ plus any appropriate outlier and add-on payment ~~as computed in ARM 37.86.2916~~; ~~and~~

(c) final payment for all patient care subsequent to 180 days will be reimbursed at ~~a rate computed by multiplying the statewide average cost to charge ratio by the usual and customary billed charges.~~ 80% of the hospital specific estimated cost to charge ratio as computed by the department without cost settlement; and

(d) the hospital must obtain authorization to bill prior to submission of the first claim and must provide medical records upon request of the department or its designated review organization for continued stay reviews.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2924 INPATIENT HOSPITAL ~~PROSPECTIVE~~ COST BASED REIMBURSEMENT, CERTIFIED REGISTERED NURSE ANESTHETISTS (1) If the Secretary of Health and Human Services has granted the facility authorization for continuation of cost pass-through under section 9320 of the Omnibus Budget Reconciliation Act of 1986, as amended by section 608(c) of the Family Support Act of 1988 (Public Law 100-485), the department shall reimburse cost based inpatient hospital service providers for certified registered nurse anesthetist costs on a reasonable cost basis as provided in ARM ~~37.86.2801(2)~~ 37.86.2803.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2925 INPATIENT HOSPITAL REIMBURSEMENT, DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS (1) Routine disproportionate share hospitals (RDSH) shall receive an additional payment amount equal to the product of the hospital's prospective base rate times the adjustment percentage of:

(a) remains the same.

(b) ~~5%~~ 10% for urban hospitals.

(2) through (4) remain the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2943 BORDER HOSPITAL REIMBURSEMENT (1) Inpatient hospital services provided in border hospitals will be reimbursed under the APR-DRG prospective payment system described in ARM 37.86.2905, 37.86.2907, 37.86.2912, ~~37.86.2914,~~ 37.86.2916, 37.86.2918, and 37.86.2920~~, and 37.86.2924~~.

~~(2) In addition to the prospective rate, border hospitals will be reimbursed for cost outliers as set forth in ARM 37.86.2916, and for capital costs as set forth in ARM 37.86.2912, but shall not be reimbursed in addition to the DRG payment under ARM 37.86.2810, 37.86.2914, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2931, 37.86.2932, 37.86.2935, and 37.86.2940.~~

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2947 OUT-OF-STATE HOSPITAL AND CENTERS OF EXCELLENCE REIMBURSEMENT (1) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana will be reimbursed

~~50% of usual and customary billed charges for medically necessary services~~ as provided in ARM 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2916, 37.86.2918, and 37.86.2920.

(2) Medicaid reimbursement for inpatient services shall not be made to hospitals located more than 100 miles outside the borders of Montana or Centers of Excellence unless the provider has obtained authorization from the department or its designated review organization prior to providing services. All inpatient services provided in an emergent situation must be authorized ~~within 48 hours~~ as described in ARM 37.86.2801(4)(d).

(a) Should prior authorization not be obtained, reimbursement will be 50% of the amount as calculated in ARM 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2916, 37.86.2918, and 37.86.2920 for services determined to be medically necessary.

(3) A Center of Excellence is an out-of-state or border acute care medical hospital as defined in ARM 37.86.2901 that:

(a) provides through its main hospital or on-site affiliate all specialty and subspecialty medical care; and

(i) has a medical school affiliation; or

(b) provides a specialized medical service not available elsewhere; and

(i) has a medical school affiliation; and

(ii) conducts bench to bedside research.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

5. ARM 37.86.2914 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, MEDICAL EDUCATION COSTS, as proposed to be repealed is on page 37-20457 of the Administrative Rules of Montana.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

6. The Department of Public Health and Human Services (the department) is proposing these rules to amend the Medicaid reimbursement methodologies for inpatient hospital services. The proposed new reimbursement methodology for most hospitals would be based on All Patient Refined Diagnosis Related Groups (APR-DRGs). Only exempt hospitals, critical access hospitals, and preferred out-of-state hospitals would be reimbursed based on a hospital specific Medicaid inpatient cost to charge ratio. In addition, the department proposes to phase out the "Preferred Out-of-State" hospital services reimbursement category and the creation of a "Centers of Excellence" category. These rules are necessary to implement the new reimbursement methodologies.

In fiscal year 2006, the department paid $77.2 million for 17,324 inpatient hospital stays. Of this amount 14% went to Critical Access Hospitals, 20% to out-of-state hospitals, and the balance was made up of payments to in-state Prospective Payment (PPS) hospitals, border hospitals, and hospital specialty units. Significant categories of payment included obstetrics, neonates, pediatrics, and mental health

services. This pattern is consistent with Medicaid programs nationwide.

Montana Medicaid's current payment method dates from 1993. Payment is made on a per-stay basis using the same Diagnostic Related Groups (DRG) case mix adjustment that Centers for Medicare and Medicaid Services (CMS) used for the Medicare program (CMS-DRG). Since the Medicare and Medicaid patient populations differ significantly, the department uses customized payment methodologies for specific out-of-state hospitals, neonate intensive care units, and distinct-part rehabilitation units. It applies an age adjustment methodology to all mental health services. The department follows CMS reimbursement policy for Critical Access Hospitals (CAH) and exempt hospitals. As a result of these customizations only 38% was made by DRG. The other 62% of payments were made based on hospital-specific costs or charges, thereby providing no incentive for hospitals to reduce their costs or control their charges.

In October of 2007, CMS changed from a CMS-DRG grouper to what they call an MS-DRG grouper. The MS-DRG grouper was customized for the Medicare population. In addition, CMS made several specific statements that the MS-DRGs were intended for Medicare use only. For example:

> "We advise those non-Medicare systems that need a more up-to-date system to choose from other systems that are currently in use in this country or to develop their own modifications… Our mission in maintaining the MS-DRGs is to service the Medicare population." Federal Register, Volume 69, Number 96, page 28223.

Because CMS has been indicating for several years that i's DRG payment method would no longer be maintained for other users (specifically those DRGs for births and newborns), the department contracted with Affiliated Computer Services (ACS, Inc.), a business process and information technology services company and the department's fiscal intermediary to conduct a feasibility study in December 2006 comparing the All Patient Refined Diagnosis Related Groups (APR-DRGs) to several other payment methodologies to determine the method best suited to the needs of the department. Based on tests conducted by ACS, Inc. applied to a full year of Montana Medicaid inpatient data, the department decided that APR-DRGs would be best suited for our needs. The reasons for this decision include:

1. There are 112 APR-DRGs for newborn care compared to 7 for CMS-DRGs.
2. APR-DRGs do a better job than the other DRG methods in capturing differences in hospital resource use among different kinds of Medicaid patients.
3. APR-DRGs also do a better job in capturing the complications and comorbidities of Medicaid patients.
4. APR-DRGs while simplifying Medicaid's payment methodology also allow the department greater flexibility.

The department formed a workgroup that met monthly with the Montana Hospital Association (MHA) and any affected parties who wish to participate.

As a result of these meetings the department made the following major decisions:

a. The department will apply the APR-DRG payment methodology to in-state PPS hospitals, out-of-state-hospitals, newly designated Centers of Excellence hospitals, border hospitals, distinct part rehabilitation units, including Long Term Care Hospitals (LTCH), and distinct part psychiatric units.

b. The only hospitals exempt from APR-DRG will be CAH, Indian Health Services hospitals, Montana State Hospital, and exempt hospitals.

c. National lengths of stay will be utilized.

d. Relative weights of APR-DRGs will be recentered so that the average Montana Medicaid stay has a base weight of 1.00 prior to applying policy or age adjusters.

e. Adjustments will be applied to specific weights to reflect department policy (i.e., increase reimbursement for newborn stays, neonate stays and children's mental health stays).

f. There will be one overall base price and an enhanced base price for distinct part rehabilitation units (including LTCH) and for hospitals designated as Centers of Excellence.

g. Centers of Excellence hospitals will be a new designation for hospitals that provide services at a higher level of comprehensive care and are essential to Montana Medicaid to provide access to care otherwise not available (i.e., heart transplants). The department will determine which hospitals meet this designation. All stays in these hospitals will require prior authorization.

h. Capital expenses will now be included in the base DRG payment. The only add-on expense to APR-DRG will be for services rendered by Disproportionate Share Hospital (DSH) providers. CMS has determined under the Waxman bill that state Medicaid programs may not reimburse hospitals for medical education and the department will implement that determination.

i. Any hospital may now interim bill for inpatient stays of at least 30 days. The hospital may bill every 31 days and will receive a flat per diem rate. At discharge, the hospital may adjust the interim bills and submit one bill for payment under APR-DRG.

j. Based on recommendations from the MHA workgroup the department is moving away from CMS bundling rules and instead will simplify the rule by requiring that any service on the day before or the day of the inpatient stay be bundled, except dialysis services. This will not apply to cost based hospitals.

k. All out-of-state hospital and Centers of Excellence stays will require

prior authorization. Those hospitals that do not obtain prior authorization but provide emergent or medically necessary services will be reimbursed at 50% of APR-DRG.

ARM 37.86.2801

The proposed changes reference the ARM sections that apply to the new payment methodology. Changes are also being proposed for the prior authorization requirements.

ARM 37.86.2803

The department is proposing changes to update CMS references and references to the ARM sections that apply to the new payment methodology.

ARM 37.86.2901

The changes include updates to old definitions and the addition of new definitions.

ARM 37.86.2902

The changes proposed for this rule are intended to clarify that alcohol and drug treatment services are for detoxification. In addition to the designated review organization the department would also be able to authorize or deny more than four days of services.

ARM 37.86.2904

The department is proposing to adjust the requirements of the physician notice to reflect the fact that APR-DRGs use all diagnosis and procedures in its grouping methodology. This rule would also be amended to specify when a hospital may submit a claim.

ARM 37.86.2905

The proposed changes delineate the general reimbursement differences between prospective payment services (PPS) and cost based hospitals. They would eliminate references to "preferred" hospitals, a designation which would end September 30, 2008 with the advent of Centers of Excellence hospitals. Language would be added to allow interim billing and statewide cost to charge ratios that are now separated by type of hospital.

ARM 37.86.2907

The proposed changes would define how relative weights are calculated for APR-DRG. They would update the new base rate payments and eliminate cost based

payments to neonate units.

ARM 37.86.2912

This rule would be changed so that capital-related expenses would be included in the base payment.

ARM 37.86.2914

The department proposes repeal of this rule to conform to the CMS decision that, based on the Waxman bill, state Medicaid agencies are not allowed to reimburse hospitals for medical education costs.

ARM 37.86.2910 and 37.86.2916

The proposed amendments would make changes to the language of these rules so that the DRGs now used would be APR-DRGs.

ARM 37.86.2918

The department proposes to add language to allow for partial eligibility reimbursement. The amended rule would reflect the change to an outpatient bundling reimbursement methodology. There are also changes proposed that would specify which types of hospitals or distinct part units the reimbursement methodologies would apply to.

ARM 37.86.2920

The department proposes this rule be changed to allow for interim billing of hospital resident claims and to change final payment methodologies to the proposed methods.

ARM 37.86.2924

This rule would also be changed to show that Certified Registered Nurse Anesthetist cost based reimbursement is limited to cost based hospitals.

ARM 37.86.2925

The only change to this rule would be to increase the DSH reimbursement factor for urban hospitals to 10%.

ARM 37.86.2943 and 37.86.2947

These rules would be changed to reflect the new reimbursement methodology for border and out-of-state hospitals. ARM 37.86.2947 would also be amended to add the requirement that all out-of-state hospitals must obtain authorization prior to

providing services. The requirements for a Center of Excellence hospital would be added to ARM 37.86.2947.

NEW RULE I

The proposed rule would be an independent section to summarize reimbursement methodologies for cost based hospitals which would be limited to CAH and exempt hospitals. Preferred out-of-state hospital reimbursement would terminate for dates of admission after September 30, 2008.

FISCAL IMPACT

The rule changes proposed in this notice would be neutral to the inpatient appropriation. Even though they are appropriation neutral, some hospitals will see increased revenues as a result of these proposals and some will see reduced revenues. The department anticipates that Medicaid payments to in-state hospitals overall will increase by 10%. Overall payments to border hospitals will increase by 12%. Overall payments to out-of-state hospitals will decrease by 19%. Montana Medicaid payments to Centers of Excellence will decrease 16% and those to distinct part rehabilitation units will increase by 6%.

PERSONS AFFECTED

The proposed rule changes would affect all inpatient hospital stays except at CAHs and exempt hospitals. There are 15 in-state hospitals, six specialty hospital inpatient units, two LTCHs, 15 border hospitals, ten newly designated Centers of Excellence hospitals, and 42 out-of-state hospitals expected to be affected by this rule.

7. The department intends for the proposed adoption, amendment, and repeal of rules to be effective October 1, 2008.

8. Interested persons may submit comments orally or in writing at the hearing. Written comments may also be submitted to Rhonda Lesofski, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena MT 59604-4210, no later than 5:00 p.m. on July 24, 2008. Comments may also be faxed to (406)444-1970 or e-mailed to dphhslegal@mt.gov. The department maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. To be included on such a list, please notify this same person or complete a request form at the hearing.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this notice conform to the official version of the notice as printed in the Montana Administrative Register, but advises all concerned persons that, in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text

will be considered. The web site may be unavailable at times, due to system maintenance or technical problems.

10. The bill sponsor notice requirements of 2-4-302, MCA, do not apply.

11. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

| | |
|---|---|
| /s/ John Koch | /s/ Joan Miles |
| Rule Reviewer | Director, Public Health and Human Services |

Certified to the Secretary of State June 16, 2008.